No. 2
-1/47
5-17-39

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 23 1947

Registration District No. 1997

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 31105

Registrar's No. 3819

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital No. 1 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo. 7 days (Specify whether years, months or days)
In this community: unknown.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson 46
(c) City or town: Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No.: 1010 E. 12 St. 8
(If rural, give location) 0
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Abraham L Blankenbaker
3. (b) If veteran, name war: no
3. (c) Social Security No.: 495-05-6241
4. Sex: Male
5. Color or race: W
6. (a) Single, widowed, married, divorced: Wid 2
6. (b) Name of husband or wife: Nora
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: No Record (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
about - 67			hr. min.

9. Birthplace: Mo. 0 (City, town, or county) (State or foreign country)
10. Usual occupation: Retired
11. Industry or business: RR Fireman
FATHER
12. Name: Blankenbaker
13. Birthplace: Va (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: No Record
15. Birthplace: No Record (City, town, or county) (State or foreign country)
16. (a) Informant: John Blankenbaker
(b) Address: 1217 Baltimore
17. (a) Removal (Burial, cremation, or removal) (b) Date then: Sept 8-1947 (Month) (Day) (Year)
(c) Place: burial or cremation: Rich Hill Mo.
18. (a) Signature of funeral director: Mrs C R Foster
(b) Address: 918 Brooklyn
19. (a) 9-8-47 (Date received local registrar) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 7 year 1947 hour 8 minute P. M.

21. I hereby certify that I attended the deceased from July 31, 1947, to Sept. 7, 1947, that I last saw him alive on Sept. 7, 1947, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Subarachnoid hemorrhage	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: gsw	
Of autopsy: See above	

PHYSICIAN — Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify):
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place) 0
While at work? (e) Means of injury:

23. Signature: Wm W Hart (M. D. or other) MD
Address: Med. Dir. Gen'l Hosp. Date signed: 9-7-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

Dr Werner

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Dean Owens

Licensed Embalmer No. 4280

P. O. Address 918 Brooklyn K. C., Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.